AN EXPLORATORY STUDY OF THE USE OF NONVERBAL COMMUNICATION IN IDENTIFYING A THEME IN A NURSE-PATIENT RELATIONSHIP

by

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CHAPTER I

INTRODUCTION

Introduction to the Study

The basic nursing unit consists of two persons, the patient and the nurse, in a constant interchange of needs and services in order to achieve optimal health and satisfaction. These two individuals bring their past experiences and expectations to the present situation and attempt to find ways to express, understand, and act upon them. The distinctive function of nursing has been described as giving:

> . . . close and individual service to the patient, performing for him what he cannot do for himself, giving supportive care, physical and emotional, to bring him through dependence to self-directive activity toward his own health.[1]

The daily nursing events of feeding, bathing, socializing, and providing treatments vary in every situation as the particular nurse-patient combination varies. However, the meaningfulness of these activities as movements toward health is often obscured leaving many questions. Why did the patient get well in spite of the extremely poor

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[1]Report of Work Conference for Regional Planning for Nursing and Nursing Education (Columbia University, New York: 1950), cited by J. Frank Whiting, "The Nurse-Patient Relationship and the Healing Process" (Pittsburgh: American Nurses' Foundation, Incorporated, 1958), p. 3. (Mimeographed).

prognosis? Why did another patient seem to resist all efforts to help him? What seemed to be the reasons that one nurse was so successful with a "difficult" patient? How do patients express their needs and how do nurses meet them?

Within the context of viewing nursing as an interpersonal process, it was considered by the investigator that this relationship is established and maintained by the communication between the nurse and the patient. This operates to a large degree on a nonverbal level as messages are conveyed back and forth by changes in the body language, such as posture, touch, mood, expression, voice tone, gestures, and behavior. However, very few accounts of actual nurse-patient relationships have been recorded and made available for analysis.

In all areas of nursing--hospital, home, and clinic--studies of the interaction between nurses and patients would be helpful in better understanding how nurses are functioning. In the psychiatric setting it is an important part of the treatment program. Black described the nurse as using her knowledge to recognize early signs of how the patient habitually expresses his anxieties and to help him to find more healthy ways to relieve them. Relationships which enable the patient to re-establish contact with others and move forward toward better emotional health are part of dynamic nursing care and grow out of "careful appraisal of the emotional and personality factors operating in the patient's illness, and of the resources of the nursing personnel assigned to his care."[1]

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[1]Kathleen Black, "Appraising the Psychiatric Patient's Nursing Needs," The American Journal of Nursing, 52:720, June, 1952.

The role of the psychiatric nurse, according to Gregg, is to create an interpersonal environment in which the patient will have an opportunity to develop new and more effective behavior patterns. Some of the possible experiences in such a situation include those of:

> . . . being accepted and respected as a person in his own right, with the freedom to talk out his problems and act out his conflicts--within the limits of safety and group living--without censure or sanction. Such an environment allows him to communicate his feelings, to examine his thoughts and actions, and to make choices and test out solutions to his problems. As communication is established with the patient, some understandings are possible, his needs can be recognized, and provisions to help him meet them begin to be made.[1]

The need for therapeutic interpersonal relations through more effective communication has been increasingly recognized in the nursing profession. A group of psychiatric nursing specialists reported:

> Of all the situations in which the nurse needs communication skills, the most important is in her work with patients. This is also likely to be the area in which proficiency of communication is the most difficult to attain. . . . One of the characteristics which distinguishes psychiatric patients from other sick people is the inability of many of them to utilize ordinary means of communication. Some, for long periods of time, do not talk; others talk "in riddles." In working with them, nurses must learn a whole new system of language, the language of inflections in speech or of gestures, changes in posture, or other actions.[2]

The group regarded the area of nonverbal communication as an uncharted realm and suggested that a researcher could make "discoveries, not merely rediscover principles and facts that have been validated by her predecessors."[3] The report concluded that in studying nonverbal

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[1]Dorothy Gregg, "The Psychiatric Nurse's Role," The American Journal of Nursing, 54:848, July, 1954.

[2]The Education of the Clinical Specialist in Psychiatric Nursing (Report of a National Working Conference, Mental Health and Psychiatric Nursing Advisory Service, National League for Nursing, Williamsburg, Virginia, 1956, New York: National League for Nursing, 1958), p. 50.

[3]Ibid., p. 51.

communication psychiatric nursing has an opportunity to make a real contribution.

Nahm,[1] in summarizing recent research in psychiatric nursing, stated that participant observation was a means to evolve hypotheses of nurse-patient relationships which could be tested through further research. These studies were characterized as being less structured than traditional research and much more subjective and dependent on the impressions of the researcher. At this stage of development of psychiatric nursing, she saw this method as not only essential, but highly desirable.

The circular relationship of research and clinical application was suggested by Schwartz and Shockley in stating that although many nurses have been dealing therapeutically with patients for a long time, their knowledge and experience have not been recorded and organized to be available for others. They stated:

> . . . The nurse has not been reluctant to share her knowledge and experience, but sometimes she has been unable to explain clearly and precisely what she does that helps the patient, how she does it, why she does it that way, and how she knows when she has been helpful. Frequently, she may not know exactly what she does do. She may recognize the activities that are useful for patients but be unable to formulate her thoughts and feelings and describe them either to herself or to others. Or she may be clear about each of her individual actions and relations with patients but not have an adequate framework by which she can organize a wide variety of relations with patients into a coherent picture.[2]

Probing into such questions by research was urged in order to accumulate public knowledge about the psychological life of patients.

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[1]Helen Nahm, "Research in Psychiatric Nursing," Nursing Outlook, 5:90-1, February, 1957.

[2]Morris S. Schwartz and Emmy Lanning Shockley, The Nurse and the Mental Patient (New York: Russell Sage Foundation, 1956), p. 15.

Unless there were articulate and public knowledge, Sanford warned that "every young nurse must start from scratch and can learn only through the too inefficient, too protracted, and often too uneducative school of direct experience."[1]

The problem which initiated the study was the recognition of the gap between concepts of nursing as an interpersonal process and recorded material to substantiate these. Nonverbal communication was focused upon in an effort to put into words some of the vague, puzzling, and highly important ways in which the interaction of a nurse and a patient was expressed.

Purpose of the Study

The purpose of the study was to identify and examine the themes of a specific nurse-patient relationship by concentrating on the observed nonverbal communication in the situation. This would provide a descriptive study of one instance of nursing care in a psychiatric setting which would help to illustrate how a nurse had functioned.

It was recognized that the conclusions that might be drawn would be individualized for this specific relationship. However, by examining the possible meanings of the behavior in this situation, the investigator might be able to formulate a framework to be used by other nurses in similar settings. A description and examination of the method of approach might lead to further information about interaction studies as a means of understanding and resolving problems in other areas.

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[1]Fillmore H. Sanford, "The Behavioral Sciences and Research in Nursing," Nursing Research, 6:56, October, 1957.

Within this study it was considered that the nurse and the patient express their needs in many ways which might be more fully understood by increased awareness and examination of the observations. Better understanding could facilitate better nursing care. The importance of examining nonverbal communication as one approach to increased understanding was evaluated for nursing practice as well as a means of nursing education. Through participating in the study, the investigator hoped to expand her own awareness and explore a variety of learning situations that might be helpful to other nurses, to students of nursing, and to patients.

Definition of Terms

Within the study the following operational definitions were used.

Nurse-patient relationship. This was considered to be the continuing interaction between a nurse and a patient which resulted from their interpersonal contact and which was accessable to observation, examination, and modification.

Communication. Communication was considered to be all the processes by which one person influenced another through a continual exchange of expression, reception, and evaluation of behavior which ideally resulted in an accurate perception of the intended message.

Nonverbal communication. Nonverbal communication was considered to be aspects of communication other than by words and included such categories as body action, posture, gesture, speech patterns of tone, tempo, and quantity, mood and attitude, time, space, and inanimate objects.

Theme. A configuration of dominant, recurrent behavior patterns which were abstracted from the observed behavior in the nurse-patient relationship was referred to as a theme.

Approval. Approval was considered to be the cluster of emotional responses involved in feelings of acceptance, affection, approbation, esteem, and worth which were expressed by overt and covert means.

Aggression. Aggression was considered to be the cluster of emotional responses involved in feelings of assertion, hostility, bold and persistent self-expression, and attack as expressed by overt and covert means.

Scope, Methodology, and Sources of Data

The scope of the study was the intensive examination of a nurse-patient relationship which was established and maintained over a specified period of time for the purpose of investigation. In the relationship the investigator functioned as the nurse with the patient who was hospitalized for psychiatric illness in a large state mental hospital.

The methodology was considered to be a modified case study in which participant observation was utilized as the data collecting device. Analysis, concurrent with collection of the data, was used to alter the interaction between the nurse and the patient.

The source of the data was the interaction between the nurse and the patient as observed by the former. A record of this was examined and analyzed further through regularly scheduled conferences with a psychiatric nursing instructor.[1]

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[1]Harriett N. Burroughs.

Limitations

Limitations were anticipated within the exploratory nature of the study. The general unavailability of similar studies necessitated independent formulation of a means of approach and analysis through studying the nonverbal behavior. The written record of the interaction was recognized as being factually incomplete as distortion resulting from anxiety, fatigue, forgetting, and reluctance might occur.

The patient to be selected for participation in the study was considered to be a possible limiting factor. His unique communication system would be an important part of the study yet one that could be anticipated only vaguely.

Another important limitation was considered to be the investigator and her ability to function as a participant observer. The degree to which she would be able to interact, observe, record, and examine the behavior of both the patient and herself was regarded as a vital factor in the meaningfulness of this study and the applicability to other nursing situations.

Overview of the Remainder of the Study

Chapter II reviews related literature in order to present the frame of reference of the study. The methodology concerned with the collection and analysis of the data is described in Chapter III. A descriptive account of the specific nurse-patient relationship is given in Chapter IV, and the analysis of one theme is demonstrated in Chapter V. Chapter VI presents a summary of the study with conclusions, implications for nursing, and recommendations for further study.

CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

The dearth of recorded material dealing with nurse-patient relationships indicated that this area was an important focus for nursing research. For this study the related literature was reviewed in order to present the frame of reference in which the investigator viewed interpersonal relations in nursing.

Communication and Mental Illness

General framework. The hypothesis that "everyone is much more simply human than otherwise" was assumed by Sullivan as basic in his formulation of the interpersonal theory of psychiatry.[1] This theory was summarized as having two main propositions: one, that a large part of mental disorder results from and is perpetuated by inadequate communication as a result of anxiety, and two, that in any two-person relationship, each person is involved as a portion of the interpersonal field in processes which affect and are affected by that field.[2] Thus, interaction between people was considered to be a vital part of the formation, maintenance, and resolution of psychiatric problems. In order to participate therapeutically, the helping person must investigate his own patterns of anxiety,

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[1]Harry Stack Sullivan, The Interpersonal Theory of Psychiatry (New York: W. W. Norton and Company, Inc., 1953), p. 32.

[2]Ibid., p. xii.

communication, and modes of interaction.

Within a broad theory of communication Ruesch[1] viewed mental illness as disturbed communication. Through understanding disturbances of communication, the therapist would aim at correcting defective processes which involves not only undoing established patterns but also teaching the basic elements of human communication of which the patient may have been deprived.[2] To do so, he enters as a subjective participant which Ruesch described as:

> . . . the utilization of self as an instrument to gauge the effect the self has upon others and the impact others have upon the self. No longer is the doctor concerned with inferring motivations and intentions and behaving as if he were a supernatural observer; instead, he describes interpersonal processes in terms of the effects communication has upon the participants, including himself. The phenomenology of interpersonal communication . . . furnishes a framework in which the subtleties of two-person interaction can be understood.[3]

Two other psychiatrists extended therapeutic functioning by stating that, regardless of the type or explicit intent of the relationship, "whenever one individual engaged in an interpersonal relationship with another functions in such a way as to increase the integrative adaptative capacity of the latter, psychotherapy has taken place."[4] Their theory of the treatment of emotional illness stressed the reciprocal nature of needs

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[1]Jurgen Ruesch, "Synopsis of the Theory of Human Communication," Psychiatry, 16:215-43, August, 1953.
Jurgen Ruesch, "Psychiatry and the Challenge of Communication," Psychiatry, 17:1-18, February, 1954.

[2]Jurgen Ruesch and Gregory Bateson, Communication: The Social Matrix of Psychiatry (New York: W. W Norton and Company, Inc., 1951), p. 92.

[3]Jurgen Ruesch, Disturbed Communication (New York: W. W. Norton and Company, Inc., 1957), p. 24.

[4]Carl A. Whitaker and Thomas P. Malone, The Roots of Psychotherapy (New York: The Blakiston Company, 1953), pp. 49-50.

and strengths between the patient and the therapist which were expressed through many modes of communication during the therapeutic process.

Duality of verbal and nonverbal communication. The relationship between verbal and nonverbal aspects of communication was considered to be shifting, interdependent, and highly contextual. Ruesch and Kees expressed an opinion that it was scientifically impossible to maintain the lines of demarcation between intentional and unintentional communication through word and behavior and assumed that "any form of action, whether verbal or nonverbal, has communication function. As soon as another person interprets a signal with some degree of accuracy, it must be codified in terms that qualify as language."[1]

Ruesch stated that when verbal expressions reflect a person's actions, thinking, and feelings, his verbal productions somewhat represented his behavior. He continued, "But if verbal statements do not stand in a one-to-one relationship to action, emotion, or thinking--and such is the case in the majority of patients we deal with--then the study of verbal behavior becomes meaningless."[2]

This point was emphasized by Berne who stated:

> In the case of interpersonal relationships, in general, intended, precise, formal, rational, verbal communications are of less value than inadvertent, ambiguous, informal, nonrational, nonverbal communications; for in such cases the receiver is not interested in the information the communicant intends but in the psychological reality behind it.[3]

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[1]Jurgen Ruesch and Weldon Kees, Nonverbal Communication (Berkeley: University of California Press, 1956), p. 48.

[2]Jurgen Ruesch, "Psychotherapy and Communication," Progress in Psychotherapy Vol. 1. Frieda Fromm-Reichmann and J. L. Moreno, editors (New York: Grune and Stratton, 1956), p. 181.

[3]Eric Berne, "Concerning the Nature of Communication," Psychiatric Quarterly, 27:190-91, April, 1953.

He considered that latent communication was perceived through intuition which he defined as being knowledge based on experience and acquired through sensory contact with the subject through "pre-verbal unconscious or pre-conscious functions, so that the intuiter at first cannot formulate to himself or others exactly how he came to his conclusions."[1]

The application of this preconscious awareness was expressed in Meerloo's elaboration on many archaic acts, such as body rhythm, yawning, smiling, and skin behavior. In calling attention to possible meanings, he stated, "Not always will one find out to what regressive fantasies the communicative acts of the patient are related, but the moment they are discovered, . . . the field of observation enlarges."[2]

Empathic assessment was used to describe an individual's ability, through knowledge and experience with his own body, to infer the sensations and condition of another person. Means to do so included:

> . . . physical appearance, movements, and speech patterns. The total appearance of a person furnishes information for initial and tentative assignment of identities and roles; age, sex, body build, clothing--even temperament and intelligence--all furnish helpful clues. Since appearance, body detail, and movement are usually interpreted and assessed in terms of total configurations, logical categorization of detailed factors makes little sense; evaluated as a unit, however, these factors have unquestionable problem-solving properties.[3]

The use of body language for therapeutic benefit was discussed with the caution that the therapist must be aware and knowledgeable in

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[1]Ibid., p. 196.

[2]Joost A. M. Meerloo, "Archaic Behavior and the Communicative Act," Psychiatric Quarterly, 29:72, January, 1955.

[3]Ruesch and Kees, op. cit., p. 57.

regard to his own body and how he uses it for communication. Careful evaluation of the therapist's body language was suggested whenever a problem in the treatment of a psychotic patient arises.[1]

Successful communication was viewed by Ruesch as resulting in pleasure and gratification which contrasts with the persistent production of unresolved tension after failure to communicate. If the repetition of gratifying communication experiences occurred, the affected person would be better informed, adaptable, and capable of withstanding frustration. He proposed a continuum of mental health based on the processes of communication. Pathology would be characterized by quantitative deviation and inappropriate patterning. These were illustrated by:

Too much,
Too little,
Too early,
Too late,
At the wrong place,
Is the disturbed message's fate.[2]

Nursing and Communication

Nursing as an interpersonal process. The concept of nursing as an interpersonal process was expanded by Peplau under the supposition that the nursing process is educative and therapeutic when nurse and patient can come to know and to respect each other as individuals who are sharing

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[1]J. E. Taylor, R. R. Pottash, and D. Head, "Body Language in the Treatment of the Psychotic," Progress in Psychotherapy Vol. 4. Jules H. Masserman and J. L. Moreno, editors (New York: Grune and Stratton, 1959) p. 231.

[2]Ruesch, Disturbed Communication, p. 41.

in the solving of problems.[1] She hypothesized that a nurse-patient relationship could be regarded as four overlapping phases--orientation, identification, exploitation, and resolution--which could be identified, examined, and modified through systematic study.[2]

Sanford recognized the interpersonal aspects of nursing in stating:

> If medical care is to be truly comprehensive, and truly humane, there cannot be treatment of mere cases or mere symptoms. There must be treatment of people--whole people, complicated people, weak and strong and courageous and frightened and cantankerously individual and mousily conformist people. . . . It is the nurse who must carry the therapeutic light in this very human side of medical care. It is the human skills--skills based on both knowledge and on personal attributes--which give the nurse a highly unique therapeutic function, the true significance of which has very probably not yet been fully appreciated.[3]

In an analysis of the nursing role an important emphasis was placed on the function of the nurse as an expressive agent through direct gratifications and tension reducing activities with patients.[4] This was seen as an important means of maintaining the motivational equilibrium of the patient as he moves from illness to health.

Psychiatric nursing and communication. The concept of nursing as an interpersonal process has been viewed as very important in the treatment of emotional illness. One group characterized the mentally ill patient

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[1]Hildegard E. Peplau, Interpersonal Relations in Nursing (New York: G. P. Putnam's Son's, 1952), pp. 3-16.

[2]Ibid., pp. 17-42.

[3]Sanford, loc. cit.

[4]Miriam M. Johnson and Harry W. Martin, "A Sociological Analysis of the Nurse Role," The American Journal of Nursing, 58:375-7, March, 1958.

as bringing to the hospital his inadequate though customary patterns of living.[1] Gratification of his needs, improved communication, and social participation were areas where nursing personnel could interact therapeutically. To do so, an understanding of the feelings, thoughts, and actions of both patient and nurse was considered necessary, and this might be achieved through collaboration with the psychiatrist, conferences with supervisors and co-workers, and repeated experiences with patients.

Schwartz and Shockley[2] emphasized the struggles of a patient to make his needs manifest through his patterns of communication which might not result in gratification. They suggested that a nurse might develop increased sensitivity to the meaning of behavior if she purposefully focused on trying to understand the patient. The meeting of needs and element of sharing might encourage the expectation that similar experiences could occur again. This in itself lays the foundation for reoccurrence as:

> . . . With the accumulation of partially successful communicative exchanges, more conventional and understandable communication by the patient gradually may emerge, and the patient's feeling that he is so different from everyone else or so "crazy" that he will never be understood may be decreased.[3]

In evaluating behavior, according to Render,[4] the nurse must shift from fact to speculation while including her own opinions and experiences.

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[1]Committee on Psychiatric Nursing of the Group for the Advancement of Psychiatry, Therapeutic Use of the Self (Report No. 33. Topeka: Group for the Advancement of Psychiatry, June, 1955), pp. 1-2.

[2]Schwartz and Shockley, op. cit.

[3]Ibid., p. 232.

[4]Helena Willis Render, "Creative Aspects of Psychiatric Nursing," The American Journal of Nursing, 50:433-4, July, 1950.

The importance of recognizing that objective and subjective behavior may vary widely was stressed.

Theme identification. Peplau defined a theme as "a generalization, a summarizing characteristic, an abstraction of an event which actually consists of many details that are best summarized as this theme."[1] The use of themes was seen as increasing awareness, furnishing a foundation for better observation and recall, providing a basis for comparison with other situations, and furthering the opportunity to use reason and judgement in interacting therapeutically. She stated:

> The greatest hope of bringing about favorable change in the patient's behavior in nursing situations--through use of interpersonal relations--lies in the nurse's observation and awareness of what goes on. When she can recognize how she participates, when she can find how she affects patients, then she knows what changes, if any, she needs to make in her own behavior.
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> . . . . . .
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> Nursing participation can be viewed as one way of not repeating, not perpetuating, not reinforcing cultural experiences that have already done damage. . . . Relating constructively to patients requires constructive attack on all minor problems as and when they emerge. This can be done to some degree in the time which nurses customarily spend with patients but it requires that the nurse be able to conceptualize processes rather than products and themes rather than details.[2]

Other studies have shown that the identification of themes in a psychiatric hospital is an important part of treatment.[3]

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[1]Hildegard E. Peplau, "Themes in Nursing Situations," The American Journal of Nursing, 53:1221, October, 1953.

[2]Hildegard E. Peplau, "Utilizing Themes in Nursing Situations," The American Journal of Nursing, 54:327-8, March, 1954.

[3]Gwen E. Tudor, "A Sociopsychiatric Nursing Approach to Intervention in a Problem of Mutual Withdrawal on a Mental Hospital Ward," Psychiatry, 15:193-217, May, 1952.

Kenneth L. Artiss (ed.), The Symptom as Communication in Schizophrenia (New York: Grune and Stratton, 1959).

William Caudill, The Psychiatric Hospital as a Small Society (Cambridge: Harvard University Press, 1958).

Participant Observation

Therapeutic aspects. Participant observation was considered by Peplau to be the means by which the nurse takes part in the patient's continuing struggle to locate, clarify, and solve his problems. "To do this, the nurse needs to examine herself, to understand the meaning of her own actions, and how her feelings enter into them," she stated in stressing the importance of viewing the patient's behavior as being in response to something.[1] In this way, the nurse becomes a party to the interaction and an observer of it at the same time.

Schwartz and Shockley[2] concluded their study by suggesting that the nurse become a participant observer who is able to see the patient as he is and as he might become. By evaluating the nurse-patient relationship, the nurse might learn to help the patient achieve greater satisfaction, security, and mental health.

To fulfill this sort of therapeutic function, according to Fernandez,[3] the nurse needs an opportunity to question, clarify, and validate her feelings with someone else in order to identify the roles she is assuming and the effect of her behavior.

As a participant observer, the nurse may encounter similar problems to those of other disciplines. Working intensely with a psychotic patient

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[1]Hildegard E. Peplau, "Themes in Nursing Situations," The American Journal of Nursing, 53:1345, November, 1953.

[2]Schwartz and Shockley, op. cit., pp. 283-4.

[3]Theresa M. Fernandez, "Therapeutic Functions," The League Exchange, No. 26, Aspects of Psychiatric Nursing, Section A, Concepts of Nursing Care, (New York: National League for Nursing, 1957), p. 14.

exposes an individual to extreme ambivalence which results in anxiety. In a study of doctor-patient relationships, a supervisor who could help the therapist to understand the interaction was considered vital to withstanding the anxiety and mobilizing it for therapeutic benefit.[1]

Research aspects. The utilization of participant observation as a research device was elaborated in detail by Schwartz and Schwartz.[2] They defined participant observation as:

> . . . A process in which the observer's presence in a social situation is maintained for the purpose of scientific investigation. The observer is in a face-to-face relationship with the observed and, by participating with them in their natural life setting, he gathers data. Thus, the observer is part of the context being observed, and he both modifies and is influenced by this context.[3]

This process was viewed as the interrelationship of registering, interpreting, and recording through the use of the human instrument for collecting data. The chief sources of distortion were considered to be anxiety and bias which, through awareness, could be reduced or used as an additional field of observation.

Conclusion

The literature was reviewed in order to present the theoretical foundation of the study. Mental illness was viewed as disturbances in

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[1]Elvin V. Semrad et al., "A Study of the Doctor-Patient Relationship in Psychotherapy of Psychotic Patient," Psychiatry, 15:377-85, November, 1952.

[2]Morris S. Schwartz and Charlotte Greene Schwartz, "Problems in Participant Observation," The American Journal of Sociology, 60:343-53, January, 1955.

[3]Ibid., p. 343.

interpersonal relations as demonstrated through communication; nonverbal communication was considered extremely important in understanding and treating mental illness. Psychiatric nursing was viewed as participant observation in which the nurse-patient relationship is utilized to improve communication for therapeutic benefit. The use of themes in the relationship was considered to be a means by which this might be accomplished.

CHAPTER III

METHODOLOGY

Introduction

The study was viewed as an exploratory investigation of a problem area in psychiatric nursing. The methodology was considered to be a modified case study in which the unit of study was a nurse-patient relationship. A case study, as defined by Good and Scates, takes into account all pertinent aspects of one thing or complex situation as the combination of factors is examined to determine the existing status and to identify the causal factors operating.[1] The method was classified as being modified because examination was concurrent and affected the interaction.

The data-gathering device used in the study was that of participant observation. This device served the dual function of providing nursing care and data for investigation.

Preparation for the Study

Prior to the actual collection of data, the investigator attempted to sensitize her communicative abilities of observation and perception. Within the structure of academic studies, she concentrated on communication. In group and individual conferences she became more aware of her

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[1]Carter V. Good and Douglas E. Scates, Methods of Research (New York: Appleton-Century-Croft, Inc., 1954), p. 726.

modes of interaction with others. Field work with intensive study of two nurse-patient relationships served as a preliminary testing of participant observation.

Outside of specific psychiatric nursing courses, other channels for developing awareness were explored. The investigator participated in a class of modern dance to increase a sense of her own body movement and to study the communicative aspects of action, expression, tempo, and use of space. She experimented with amateur dramatics and looked for nonverbal behavior while viewing movies. Literature, such as "Hands," was read for more than the words.[1] The ski slopes supplied information regarding body control and reactions to frustration. She watched herself and others. In short, the investigator became communication conscious.

The Setting

The data were collected over a six week period at a large state hospital for the mentally ill. The ward in the study was a locked, men's treatment unit with approximately sixty patients in varying degrees of illness. It was selected on the basis of the type of patients as compared with those on other wards and isolation from the investigator's function as a student instructor. The isolation was considered necessary to allow concentration, to record more accurately, and to reduce anxiety in relation to participation. The total ward area was utilized.

The investigator saw the patient on three consecutive days weekly. This usually occurred in the late afternoon following her other obligations.

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[1]Sherwood Anderson, "Hands," Winesburg, Ohio (New York: The Modern Library, 1919), pp. 7-17.

The time was flexible, and the actual duration of the interactions ranged from fifteen minutes to an hour with the usual time between thirty and forty-five minutes.

The Participants

In this setting the investigator had no administrative responsibilities, and this modified certain usual nursing activities, such as giving medications and participating in ward decisions. Outside of that factor and her exclusive focus on one patient, she attempted to interact as she assumed she would in other psychiatric nursing situations.

The patient was selected as described in Chapter IV.[1] He had been admitted to the hospital two days previous to the day that the study began and was transferred to the specific ward on that day.

Conferences between the investigator and the instructor were held once or twice weekly, depending on the need, to discuss the relationship. The written interaction notes were examined during the sessions which lasted approximately ninety minutes each.

Recording of the Data

The recording of the data was done in a three step operation. First, in the clinical setting, participant observation was used in the collection of the data, and this process of registering, interpreting, and recording of the interaction was carried on mentally during the time spent with the patient. The investigator attempted to be as aware as possible of the communication network and yet maintain spontaneity.

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[1] Infra, p. 27.

Secondly, the transcription of the interaction was made immediately on leaving the ward. Scratch notes of key actions, words, and feelings provided a guide for more accurate sequence and content. These notes were expanded through retrospection as the investigator tried to recall the interrelationship of her behavior--actions, thoughts, feeling and words--with the patient's behavior as expressed verbally and nonverbally.[1] Inferences of his feelings were included as well as the social context. A complete reproduction of the original interaction was aimed for, but interferences to this goal were recognized. These included memory gaps, inadequate observation of the investigator's outward behavior, and the difficulty in recording the voluminous and complex material.

Data were also collected on the general framework of the mood and experiences of the investigator immediately prior to some of the interactions. Recognition of the conferences between investigator and instructor was made, but was not elaborated.

The third stage of recording evolved through the conferences as additional information was obtained by using the interaction notes to discuss what was recorded as having happened. An expansion of the original material occurred through the process of concentration, validation, and clarification. More fringe material was brought into recall, and additional meanings and relationships of the behavior were explored. These were included in the original record.

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[1]Appendix A.

Method of Analysis

The method of analysis occurred in two stages--concurrent with the study and in retrospect. During the study the device of participant observation necessitated continual analysis of the meaning and motivation of every communicative exchange. This was carried further during the recording and through the conferences. From these sources large amounts of raw data were collected.

The retrospective analysis was based on this data in a close examination of the total record of the nurse-patient relationship. This more specific form of analysis emerged gradually through four stages.

Categorization of each interaction. The interaction notes for each day were reviewed to refine the data into seven divisions--mood and experiences of the nurse before coming to the ward, moods of the patient during the interaction, areas of the ward where the interaction took place, specific modes of nonverbal behavior, general themes, material discussed in conference, and influence of other people.[1]

This extensive examination provided greater awareness of the totality of the relationship, and it led to the conclusion that the seven divisions should be presented in context in order to have communicative value.

Descriptive account of the total relationship. The descriptive account of the nurse-patient relationship served the dual function of providing a study of nursing care and of continuing the process of analyzing it. The preceding categorization formed a framework in which the raw data were reviewed again. The chief difficulty was the balance between condensation and clarity. Everything seemed important, but nonverbal communication was

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[1]Appendix B.

emphasized.

The investigator summarized the total interaction by describing the interplay of her thoughts, feelings, and actions with the behavior of the patient. Verbatim material was presented in context to show the connection between verbal and nonverbal communication. The concurrent analysis was demonstrated by the speculations of the meaning of behavior as formulated at the time of the interaction, during the recording, and through the conferences. Chapter IV presents this descriptive account.

Summarization of weekly patterns. Increased familiarity with the data through writing the descriptive study led to the impression that the behaviors of the nurse and the patient and the areas in which interaction occurred formed definable patterns. Therefore, the descriptive study and categorization were re-examined within this framework.

A general theme for each week evolved through this inspection.[1] The themes formed a continuum of the phases of the nurse-patient relationship from orientation through identification and exploitation to termination.[2] These phases were considered too general to illustrate the use of nonverbal communication, and when attention was directed toward a more specific identification, one dominant theme emerged into consciousness.

Identification of one theme in the nurse-patient relationship. Through viewing the data from several perspectives, a theme was isolated--the fluctuations of the expression of approval and aggression. The descriptive study, the categorizations, and the weekly patterns were used

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[1]Appendix C.

[2]Supra, pp. 13-14.

in this final identification. Emphasizing nonverbal components, a description of the behaviors of the nurse and patient was made to point out this theme in the phases of the relationship. Chapter V presents this identification of one theme.

Conclusion

Preparation for the study explored a variety of experiences. The methods of collection and recording of data were adapted for this investigation. The analysis was a cumulative, though groping, process. Each re-examination resulted in new understandings. It was recognized that the specific theme was one of several which could be abstracted from the interaction.

Several difficulties were encountered in analyzing the data. The lack of a prescribed structure from other studies necessitated a unique formulation. Recording and reviewing were very time consuming and were complicated by the quantity and complexity of the data. The attitudes of the investigator toward her nursing behavior fluctuated and affected her ability to review the material.

Throughout the period of analysing the data, the instructor continued to work with the investigator to help clarify, validate, and explore ways in which to present the study.

CHAPTER IV

DESCRIPTIVE ACCOUNT OF THE NURSE-PATIENT RELATIONSHIP

Introduction

The problem which initiated the study was the paucity of recorded clinical material to substantiate concepts of nursing as an interpersonal process. This chapter describes a nurse-patient relationship in a psychiatric setting. Though the focus was on the nonverbal communication, verbal behavior and context were included for clarity.

First Week

"Who is to be my patient?" The nurse went to the ward with grim determination to select a patient for study. Unfamiliarity with hospital geography and regulations made her feel anxious and angry as the staggering possible choices among the 3,000 patients seemed an ironic barrier to the establishment of a relationship with just one. The uncertainty involved in the study loomed ominously as the allotted time for data collection grew shorter. Earlier, during a lecture, the detailed description of a nurse's therapeutic interaction with an autistic child had only increased her sense of inadequacy and regret for not following through on a similar opportunity.

The previous three weeks had been a period of acclimation to a large state mental hospital and the role of student clinical instructor. Psychiatric nursing in theory and practice had been discussed, reformulated, and initiated in contacts with students and patients. Increased interest in nurse-patient relationships was counter-balanced by reluctance to begin

a study in which her own behavior would come under close scrutiny with indefinite outcome. Intellectually, the problems of getting started could be evaluated; emotionally, she wanted to give up, to walk in the country, to wait until the next day.

To the attendant the nurse explained the study and the general sort of patient she was considering--someone who was "psychotic, out of it, preferably inactive and withdrawn, young, hard to reach, and hard to understand." Patients who were reported as being well able to talk and socialize were passed over as well as one older depressed man. She knew her facade of composure was very shaky, and tears of frustration and depression were close to the surface. Initial rejection would be just too much.

A new admission, a nineteen year old boy, was described as a "real bad patient." The report from the receiving ward stated that he had been in restraints for assaultiveness, was actively hallucinating, and was a voluntary committment. The tentative diagnosis was paranoid schizophrenia. Linking his name and description--medium build, blond crew-cut, and horn-rimmed glasses, she realized they had exchanged inquiring glances as she came in. The nurse decided he was to be her patient.

The attendant called him, and she immediately wished she had waited to approach him without making an initial demand. Wondering if his washed face and slicked down hair had been to look more presentable, she asked with a smiling, friendly tone, "Hello. You're Ted Sonderson, aren't you?"

"Yes, I am." The slight smile and hesitation seemed as if he weren't quite sure or wondered what difference it meant to this new nurse.

"I'm Miss Prodan. I'd like to talk to you for a few minutes." This was to structure the immediate relationship.

"Well, O.K. Fine." As they walked down the hall, he ignored a suggestion about the smoking room and turned into an open alcove. She wondered if visiting were allowed here and hesitantly sat down on a bed.

As he looked down and fumbled with a corncob pipe, she blurted out, "Ted, I'm a nurse here and I'm going to school, too. I'm studying how a nurse and a patient get to understand each other. To do this I'd like to come visit you regularly."

"Sure, that'd be great," he replied quickly, but it seemed this meant little to him--it was her concern, not his. He questioned, "Say, don't you have any other names?" The factual answer brought a disappointed tone as he said, "That's too bad. Well, I'll see you." He walked away swiftly.

Taking stock of what had transpired so rapidly, she speculated. What did he mean? How does he see my visits? Was this enough of an introduction? Why did he initially reject me? To convey the attitude that she wanted to understand him and that this relationship would be different from social contacts, the nurse approached him again.

Instantly he asked, "Say, are you sure you're not J.R.?"

"Who would I be if I were?"

"My girl friend--she's J.R."

By replying in a similar code, she tried to talk his way to identify herself. "Well, how will it be if I'm S.P.--your nurse?" His condescending reply that it wouldn't be as good was followed by dealing two poker hands. It seemed that he was at a loss as to how to interact but made no verbal comment to her inquiry, "Maybe you're wondering what we will be doing when I come to visit--play cards or talk or what?" He shifted the game to

blackjack, and the lingo, (hit me; I'm good; give me another), assumed symbolic import of mutual testing and daring.

When she mentioned leaving, the patient suggested that they take a walk, and while doing so, she corrected his misimpression of her marital status. What difference did it make to him?

In an alcove he turned quickly, put his arm around her shoulder, and said something too soft to be heard. Through the surprise of his closeness, she sensed a sob and asked with concern, "What is it?"

"I'm all shook up," he sadly replied. The very choice of words recalled the patient of whom she had been thinking earlier. The nurse immediately felt closer to Ted as if transferring the maternal feelings and interpretation of his behavior from her previous experiences.

To allay and encourage his feelings she began something about his newness in the hospital then realized this had only blocked further expression as he turned away and started talking of cars. She said she would be coming on Monday, Tuesday, and Wednesday for the next six weeks to give some structure in which he could expect her. His content became more confusing as she listened for the meaning behind talk of Popeye, Olive Oil, and Bruno. With downcast eyes he proudly confided that he had written a song and after her conventional inquiry replied that the title was "Wonderful You."

The nurse personalized this as reaching out to her and wondered if she had elicited this compliment. His statement about needing his medications seemed to mean increased anxiety, and they walked to the nursing station. With a great sense of relief that the study had finally begun, she left the ward. So much had gone on--so much said and so much non-verbal communication!

The selection of the patient seemed to be by chance. He was far from a picture of mute, withdrawn inactivity. How much had his aggressive behavior attracted her? Her feelings of depression, anger, and frustration were running high as well as a need to reinforce her concepts of psychiatric nursing.

The theme of this first encounter was orientation--two people coming together with separate needs. The nurse brought the tangible structure of her thesis study, her previous experiences in nursing, and her complex network of human needs. The patient brought his needs and prior experiences, too, along with existing inadequate patterns of interpersonal adjustment and a tacit agreement to the study.

The next morning the charge attendant was approached in the interests of good staff relations. Hope rapidly deteriorated after a cool reception and being warned of the "aggressive, belligerent" patient. The attendant felt she should have picked a more "docile" person and suggested staying out of corners to keep from being throttled. Brief contact with the patient and previous experience decreased the impact of these dramatic words though she resented the intimidation.

In spite of reassuring herself, it was a very small voice that greeted Ted as he paced by. He moved away after hearing that she'd return at 6 pm.

At 5:55 he was staring at the ward clock--perhaps he was looking forward to the visit. Leaning against the wall with a dejected look, he softly slurred, "I don't feel so good."

"You don't feel good?"

"No, my mother-in-law visited this afternoon."

"Oh?" The surprised intonation stemmed from knowing he wasn't married yet her disinclination to query him directly. She had decided to be as inactive verbally as possible--to let him take the lead--to try to decipher what his words and actions were without introducing her own distortions. With this framework, they walked around the ward and stopped as he went into a small bathroom. Standing in the hall, she could hear him remark conversationally, "It's a nice day, isn't it?", as if rehearsing. His fiddling with the shower faucets started the water splashing which she was sure the attendants wouldn't like. "Can I help you there, Ted?" was her roundabout way of terminating the situation.

In the dayroom he rolled an envelope into a cigar and told her it was too bad it was only kingsize and not queensize. "I'll be with you in a minute," he apologized giving the impression that he meant in contact. Moving to the window, he played an individualized game with some Monopoly houses; she debated whether to join him. He soon returned to ask what her father did.

"My father? Would it make a difference?"

"Yeah, is he a plumber? That would be all right. If he was a baker or a mechanic or a ditchdigger--that would be all right. Just as long as he was a man." What was his father like? What was his concept of masculinity?

Traveling around the ward again brought them to the small bathroom, and waiting outside, she realized with chagrin that this location was the seclusion area known as short hall. The bathroom was connected with two individual rooms which could be closed off from the main hall. It seemed that he was taking an extra long time, and she began to worry that he shouldn't be in there alone. The consideration of telling him that she

wasn't comfortable back there because they were strangers passed as he came out and began testing the doors.

"Don't go away," he asked although very self-occupied and acting in the strange way of walking around the short hall in quick laps. "What time is it?" he asked as he went by clockwise and repeated the question a minute later. The reversal to counterclockwise circling led to speculation that maybe he was turning time back--his next comment verified this.

As he backed into a corner, it seemed he felt trapped and confused about what to do next. She tried to verbalize this by asking, "Maybe you're wondering what we'll be doing while I come to visit you?"

"Yeah, that figures--figure eights! He ran in this pattern which merged until she commented that he was going in circles. The answer was angry, "No! Squares!" Did he mean different--not one of the gang?

His level of activity rose higher as the sound of an airplane was repeated by his tapping foot and loud tones, "Bang! Bang! Bang!" When he paused to look at her and ask the time, she replied, "Are you wondering how much longer I'm staying?"

"Yes."

"Another five minutes." This specific structure seemed to encourage his direct question of, "Are you my nurse?"

She hesitated in surprise, "Well, yes, I am going to be your nurse."

Bewilderedly, he mused, "I've never had a special nurse--or any nurse at all."

To leave the subject open for further exploration, she suggested, "You probably do have questions as to why and when I'll be coming. It's all right to ask them, and I'll try to answer as well as I can."

To delay her leaving, he asked for a light for his empty pipe and then frantically rolled up the envelope cigar again. She waved goodbye.

The next afternoon she was initially ignored as Ted busily stuffed papers into the pockets of a young, mute patient. As she watched and waited and wondered, the nurse felt relieved that they were in the smoking room. His first comment was a challenge about her schooling. Then a chant began, "Sine, cosine, tangent; sine, cosine, tangent; sine, cosine, tangent."

"Sounds like trigonometry."

"No, it isn't," he sneered. "It's first year algebra. In fact, it's kindergarten arithmetic." He seemed bent on belittling the obvious attempt to understand his words. Another young patient vied for her attention, but she ignored him.

Ted sat down near her and in quiet tones spoke of not hearing from his family. Then, turning his attention to the mute patient, he gave the boy his seat. The nurse smiled yet hesitated to say anything as this seemed further testing. Fleeting regret that perhaps she should have picked the less active boy occurred. Ted abruptly questioned, "Say, didn't you tell me you were coming at 9 am?"

"No, did you think I had?"

Her reply was ignored with a critical, "Well, you're six and a half hours overdue." Suddenly, he asked if she had the keys to the lockers, and her answer was no. As he left the room to find an attendant, she realized that perhaps she did have that particular key but had refused in order to control his actions. Despite her warning of leaving soon, he dallied in the locker room and went right past her though his clean shirt

gave the impression that he wanted to look more presentable. Feeling a little foolish while tagging after him, she was rewarded by his pleased look that she hadn't left. After some verbal delay he didn't answer her goodbye.

The give-and-take of their relationship was emerging as he began to test her interest through rejection. Despite an awareness of the significance of these rebuffing measures, the nurse responded by such counter measures as threatening to leave, refusing help, and regretting her choice of patients.

Second Week

During the four day interval the nurse discussed with the instructor the first week's interaction notes. It had become obvious that the patterns of nonverbal communication were vague and varied, and she decided to continue recording as much as possible of the total behavior.

Ted was pacing slowly and slouchily. On seeing the nurse, he murmured, "Oh, no," and then softened this rejection by offering her a chair. She told him how long she was staying to give him some time structure.

In sad, weary tones he droned, "I had to learn it all by myself." Life? The rest was sing-songed, "Nobody taught me mathematics--I had to learn it all by myself. I lost out. Mathematics--I lost out. English--I lost out. I went to vocational technical school--lost out. Then I was in the service, well, ten days, and I came before the court martial and lost out. That's all. That's all there is to it."

"It sounds like you're thinking over your past, and it makes you sad?" Perhaps thinking she wanted his history, he concluded, "That's all

there is--you know what it all is."

She really didn't know and told him so in a puzzled, interested tone to which he repled that his mother was a nurse. Her thoughts raced. Does he see me as his mother? Are all nurses mother to him? What kind of relationship did they have? Does he think that I automatically know what has happened to him and what to do about it?

He was called to be examined by a medical student, and in the interim the attendant told her that every night the patient was locked in his room because otherwise he would get up many times, walk around the ward, and cry like a five year old. She felt very sorry for his frightened loneliness yet realized her limitations in working with the staff responsible for managing ward behavior.

Ted's confusion and depression seemed increased after the mental examination. Piqued by the interruption, she expressed concern for his sleeping difficulties. On the verge of tears he replied sadly, "Trouble? No, but I don't sleep. All night long, I just rest."

"You look so sad..," her observation trailed off as he surrendered in a dejected tone, "Go ahead. Do whatever you want to do--it's all right. Boss me around. Go ahead and leave if you want to. Anything you want to do is all right." He agreed that he did feel lost and asked if she did, too.

Trying to convey confidence despite her newness, she asked, "What gives you that impression?"

"Well, I've never seen you here before." He negated her existence. As she restated her purpose of trying to learn how she could understand better, he turned to her. "Here's the way." His arm circled her shoulder, and in response, she reached up and grasped his hand. "Just hold on," he instructed.

Despite the naturalness, she wondered what he was telling her and how anyone looking on might view the scene. She tried to explore by asking softly what it meant. "It means you're not there," he replied. How puzzling! It would seem just the opposite; perhaps he took her words as rejecting. His talk became less coherent and more intense as he seemed to be struggling with his perception of the nurse--was she mother, sister, stewardess, girl friend?

When she said goodbye, his manner and tone became firmly decisive. "Where you go, I go. If you leave, I leave." Even while saying this, he took off his sweater as if prepared to stay.

"Well, Ted, there are some things we can't do together. It's time for me to go now, but I'll be back tomorrow after 4:00." They were walking rapidly toward the locked nursing station as he continued, "Even if you walk through walls, I'll go with you. Now, figure that one out!"

She responded to the challenge with a huffy, "I don't know what you mean by that!" and then realized that the key with which she was opening the door, did enable her to walk through walls. Hurrying off the ward anxiously, she blamed herself for his agitation and feared that he might try to break the glass as he had when first secluded.

Practice teaching duties brought her to the ward the next morning. Ted was hunched up with his hand over his face. "I don't know you, and you don't know me," he stated as she sat down for a few minutes. Despite this rejection, she ignored the other patients and waited until he grudgingly admitted, "Well, I know you're there and that's all."

"Maybe you don't want me to know you?"

He replied, "That's it", but taking his hand down, he began to talk.

As she listened attentively, his sad comment was, "You're my special nurse, and you're supposed to figure me out."

On his suggestion they walked down the hall, and as if seeking greater privacy, he turned in an alcove where he compared bedmaking to diapers and spoke with discouragement of how doctors had failed at figuring him out. "I'm trying to find myself' but I'm lost, can't find the way. Oh, they give me medicine, but you're my medicine now--Olive Oil. Popeye." He laughed a little, Feeling that again he was struggling with their relationship, she suggested that he probably did have a lot of feelings about her visits.

With sad, apologetic tones he agreed, "Yes, and they're all bad." He picked up her hand to look at a ring and began to talk in a disjointed way of his lost glasses. Unable to concentrate, she started to leave.

"Where you go, I go!" His handhold detained her as it shifted to that of a small child.

"I do have to go now but I'll be back at 4:00."

"No, you won't." The disbelieving tone made her more aware of the meaning of his delaying tactics.

"Even when I say I will, you don't believe me?" Was this the crux?

"No, I don't."

"Well, Ted, I guess you don't trust me, and I don't expect you to now--you don't know me very well."

"And you don't know me. No, I don't trust you--you won't be back." As the door closed between them, she felt an exhilaration for having recognized, through the cumulated nonverbal behavior, an important area of his needs.

Of course, she was on time later and found him in much better spirits. His tone was animated, walk springy, and head high as they met. When she couldn't quite follow his talk, it didn't seem to matter so much. Even his exasperation clarified the variability of mutual understanding. When she left the ward, there was no increase in anxiety or delaying maneuvers.

Wednesday afternoon was to assume importance that she little recognized at the time. Having discussed some aspects of his background with his doctor, she went to the ward with an increased interest. Many of the things that Ted had told her, directly or symbolically, were verified more clearly.

He sat slumped near the nursing station which seemed unusual. The attendant said she'd just missed a fight--in fact, "her boy" had been in it. Not waiting for details, she hurried out to see Ted while thinking that he probably needed her. His dazed tones with confusion and fear made her encourage his verbalization of what had happened. His dilemma over being challenged stimulated her speculations over his need to prove himself, to fight his own battles, his fearfulness, and the ward management of aggression. As she listened, he leaned back with a deep sigh and misty eyes.

"That's a big sigh..," she encouraged him to share what was causing it.

"Yes, it means one thing, that's all. I love you." The nurse's eyes widened in surprise--what did he mean? In a sweeping, dreamy way he talked of how "it branches down the rivers and over the earth, through Europe and Asia and even the Holy Land, through all time and space." This all-encompassing quality awed her, and when she asked how she fit into all

this, he replied simply, "Well, you seem to be here just when I need you."

He mused on that she was his extra-special nurse and that "doctors can't figure me out--no one can. But maybe with a nurse by your side--I don't care what color skin you have--black, white, yellow, green; if you're tall or short or wide or small--that doesn't matter. Just a nurse to keep the record straight, so to speak." Her personal identity faded into the background as he struggled with his need for help.

She was affected by the strong emotional experience but felt guilty in thinking that she should have been there to prevent the fight. Later, with the instructor, the nurse achieved a more realistic expectation of herself and saw the underlying maternal aspects. Mother is the one the little boy needs after he's been hurt--not to shield him from life's experiences, but to help him understand and integrate them.

Third Week

On Monday the nurse was later than ever before in going to see her patient. She had spent the time immediately prior talking over the interaction to date and felt a sense of accomplishment, acceptance, and encouragement in her nursing functions. This was reinforced by the report that Ted was much better and after last Wednesday no longer was so upset at bedtime. She shared some of her impressions to contribute to his overall care. Her good spirits changed to speculation, guilt, and concern when she finally found him curled up in a stuporous, fetal position on his bed. Was it because she was late? Had he withdrawn even more? To her soft call, he roused easily and sat up while rubbing his eyes. "You said you'd be here Monday. Sit down. What time is it?"

"Did you think I wasn't coming?"

"Oh, no. You said you'd be here on Monday--it is Monday, isn't it?" It was almost as if he couldn't entertain the thought that she wouldn't keep her word and chose time disorientation to that possibility. Fumbling with his shoes, he couldn't untie the lace and gave her the shoe. As she struggled to help him, she felt a maternal closeness then frustration as the knot was impossible to untangle. Helping him wiggle in anyway, she thought this symbolized their relationship. Many of the knots of his life's experiences were too tight to be unraveled, but perhaps she could help him find alternate ways.

Someone passed by the seclusion area door, and her concentration lessened while wondering if they should be back there alone. Rather than delve into this vagueness with him, she suggested going to the dayroom. On the way they were asked by another patient if she were doing a case study like Ted had said. She confirmed this and noticed her patient looking away as he sadly said, "That's fine."

"Maybe it isn't so fine?" Her intention was to let him know that he could feel angry for being studied. In the privacy of an alcove he told her that she'd just have to accept him as he was and went on to talk about his past. Even in the crowded smoking room this talk continued as they formed a unit by a window. After covering school and former therapy, he said casually, "Of course, I have a wonderful mother." She wondered at his insight, his identification of her as a mother figure, and his ability to express hostility. He continued, "I have a very good family. Of course, I did try to run away several times--every day, almost. I even got as far as Highway 99."

"What brought you back?" she asked with interest.

"Well, I had to go to school the next day; that's all there was to it." His extreme ambivalence and powerlessness were expressed with simplicity.

Another patient interrupted and Ted began to stretch and shake his legs. He said it was a cramp which he needed to walk off--she thought he resented the competition. His rueful comment was that, "I've got the best ward, the best short hall, the best nurses. But I don't know why."

She thought it ironic to be classified with a seclusion room but tried to dispel the mystery of their relationship by reminding him of her study. His talk turned to hospital experiences as he said, "Like that fight--I didn't want to. But what could I do? You came just at the right time. I'm not going to fight any more--I don't have to prove anything. Next time someone comes at me, I'll sic him on you." A smile and soft tone softened this exploratory expression of hostility.

She encouraged this by a surprised, incredulous smiling, "On me?"

"Yeah, but they wouldn't get far."

"What would I do?" She continued the phantasy situation.

"Oh, stop them. I bet you'd take care of them all right."

Whether or not she would was a problem of another day. Thinking he was talking about his own aggression and her ability to tolerate it, she asked, "I wonder if you've felt like hitting me yourself, Ted?"

He looked away with a smile, "Oh, well, sometimes when I think of you, I get mad. But you always seem to come when I need you."

She refused the smoothing over of his anger by encouraging, "But you get angry at me?"

"Well, you said you would be here on Monday." The crux of his hurt, angry feelings was out. Exploration of feelings was stopped by restating her complicated time schedule. When continuing talking about school, he mentioned his difficulty with English and asked how good at it she was. Words--meanings--communication--expression all linked together. As she started to leave, he asked which way she was going.

"Does it make a difference?"

"Oh, go this way." It was the hall leading past the seclusion area to the side door. She sensed something significant, but rather than verbalizing her puzzlement, she walked along while getting out her key. Looking at the tag, he snorted derisively, 'Men's Ward! You should have stayed with the women!"

Brushing over this confusing comment, she opened the door and suddenly realized that he was going to kiss her. It was a very awkward moment. With a simultaneous action she turned her head and he kissed her nose. They both laughed a little as she left. Thinking the event over, she regarded it an expression of the emotional closeness. Yet, she wondered what was his perception. And what would be the reaction of anyone else seeing a patient kissing his nurse? This day seemed important in light of their developing relationship. Her maternal role was expanding as well as his ability to express his feelings of love and aggression.

The following afternoon she had toured the back wards and was upset by the defeat, longing, fear, and confusion of the patients there. Interest in helping her patient to reach a more satisfying resolution of his problems has heightened. With a buoyant, expansive mood and appropriate groans and gestures, he proudly showed how hard he had worked on a new ward detail.

It was only ten minutes until supper, and together they pondered whether she would come back later, wait for him, or leave. Her final decision to wait was based on hoping to convey that she could proceed at his pace--that she would wait for him to eat his supper and to get well.

With animated tones he told of his father's visit, but that his mother wasn't so good--she didn't visit him regularly. After more about his family, he looked directly at her with a little smile, "So you're not going to change me."

Wrinkling her forehead and with an off-hand tone, she minimized the threat, "What's this change you business?" He didn't need to be afraid--she wasn't out to change him. Or was she? How do you communicate that you like and accept a patient as he is and yet will work with him to "change" his ways of interacting?

She felt inclined to sit with him during supper--to reinforce the physical mothering--but the ward set-up made it too awkward. As he went to his room later, she wondered if this were a signal to leave; instead, he seemed to want to create the intimate situation of the night before. He complained about his stomach hurting and tested her verbally about seeing other patients. His whole mood seemed geared toward impressing and pleasing her--"You're the nicest girl I've ever known. . . I've never had a sister. . . I'm not like other kids. . . I've got imagination." When she said it was time to go, he blocked her exit while challenging, "Have you figured me out yet?"

Did "figuring out" mean this was her only purpose in seeing him, and when accomplished, she would leave? He seemed relieved by her answer of no.

The difficulty in talking about the kissing came out as she avoided it until they were headed down the same hall again. She began, "I was a

little surprised at the goodbye kiss you gave me yesterday."

"Oh, well, that's just the way I feel about you, that's all. I like you better than anyone." Her reply recognized his feelings of affection but gave no verbal clue of her own reactions.

The next afternoon the nurse intentionally allotted enough time before leaving for the week. Her mood was anticipatory, and his initial response was welcoming. They walked the halls and sat together in an alcove. As he stretched and yawned, she got the impression that he wanted to be cradled. Their talk was soft, pleasant, and quiet.

Suddenly, an older patient burst in by waggling his finger and saying it wasn't proper to visit there. Her surprised explanation that she was a nurse and not just visiting calmed him momentarily. Both she and Ted seemed embarrassed--each one half expected the other to leave. Instead, they continued talking though her perception was blurred. In a half accusatory, half yearning way he referred to his mother who got so upset on seeing him.

The old man came back with an adamant, "You women have gone too far! In the bedroom! Now visit out there!" She was too uncomfortable to do other than comply. Walking toward the crowded smoking room, Ted complained of the lack of privacy, and this was illustrated as another patient approached her. Her patient turned away and, as if to keep her for himself alone, suggested dubiously, "Maybe we can just walk up and down." She agreed readily knowing this to be a possible means of sharing. With a pleased look, he said, "We're right in step."

The rest of the ward was crowded, and as he didn't seem at ease just walking around, she suggested sitting in the dining room. It was almost a

refuge after being pushed around together. She leaned forward with her elbows on the table to listen, and in eager tones he asked if he were saying the right things for her report. It seemed once again he was asking if he was anything more than an object of study to her.

With groping, deliberate words her answer was, "Ted, the reason I ask you questions and talk to you isn't just for my report. Well, I really care about you. And so I'm interested in what's happened to you and how you see things now. And what you think about your future." She felt shy and looked away while saying these emotion-laden words.

He, too, looked away and replied, "Well, all I know is that when I wake up in the morning and I know you're coming that day, I'm happy. You're all the girls I've known rolled into one." Again the nurse felt caught by his complimentary words. He counteracted this move toward closeness by stating upper campus and lower campus didn't mix.

"You mean that me--nurse--psychology can't understand you--patient--engineer?" The code came from earlier talks.

"Yeah. Well, I've had psychology courses. In fact, I've known psychology ever since I was born though I guess the university wouldn't recognize that." Once again symbolic expression of a patient amazed her.

Her animation rose as she told him that she wasn't "figuring him out." "You're not a puzzle or mathematical formula that I'm unraveling. I don't think anyone can figure another person out, but like you said before, maybe I can help you to figure yourself out a little more."

"In other words, you're not a mathematician!" His loud laugh was followed by telling her more of his loneliness and difficulties with people. He asked if she could understand why he fought even when not wanting to. Her reply was that she understood him better now and probably

many of the things she said were confusing, too.

"Oh, the words aren't really important--it's the tone of your voice. Just the way you say things that makes the difference." His verbal recognition of her nonverbal communication pleased the nurse though she wondered if this were catalyzed by her own needs and focus.

It had been an emotionally close afternoon with mutual expression of caring. Standing by the door, the nurse patted his shoulder while saying, "I'll see you Monday. So take care of yourself." She cared what happened to him in the meantime.

He leaned forward, and knowing he was going to kiss her again, she offered her cheek. His eyes filled with tears as he warned, "Don't get in any auto wrecks."

Bewilderedly, she stood in the open door asking, "Auto wrecks? Are you concerned about my safety?" Later, she thought this was probably his hostile wish and fear resulting from destructive phantasies.

"Yes." She gazed searchingly until he said firmly, "You better close the door." With a sheepish smile, she did so. What did he mean? Did he want to go with her? Was it the door of affection? Was he reminding her of their nurse-patient relationship?

Fourth Week

Blue Monday. She didn't feel like going up to see him, and the cause of her depression was obscure. The instructor was unavailable due to an emergency, and the nurse regretted having their conference postponed as there were needed clarifications.

Ted met her in a restless, pressured mood as evidenced by his increased speech, quick movements, and intense look. His first words

related to the wreck making her wonder if he had worried all weekend. Sitting down, he avoided the sofa which she took as a sign to keep her distance. Previously, she had thought of bringing chewing gum for his dry mouth, but as he talked, he seemed to be chewing. He doesn't need me for even that, she thought.

He tried to talk about some confusing aspects of ward life to which she responded apathetically and returned the focus to the wreck. His denial of concern for her and emphasis on his progress led her to think he didn't need her any more. The nurse realized that she was thinking of termination and felt that misinterpretation was occurring.

As they sat at the dining room table, he mused about his search--always looking over the next hill, always wanting something. "But there's a time to stop being a boy and start being a man." Sketching some figures, he recalled one of their earliest talks. He belittled her by simplifying the diagram and sarcastically smiling, "Each one has ninety degrees and 360 degrees make a circle. You know that, at least, don't you?" He shifted in tone, "Well, sometimes you look and look for something and sometimes you find it. It's like freedom. Why, if a man has a belief in freedom, he'll die for it, and that proves his belief, doesn't it? But faith is different, I've found it."

She found it hard to follow and tensed up as he talked of dying. Her concern that he was talking about suicide might have been her own unconscious hostile wishes. She tried to pin him down to say he had found a better way of living through their interaction, but he dodged this.

He theorized, "Well, you could make a whole lot of formulas--all the way from here to here--crossing this whole room--all kinds of figures and what would you have? A whole bunch of nothing!"

She laughed suddenly and shook her head.

"Don't laugh! It's true!" Quizzically, he looked at her.

"I know it's true. That's why I'm laughing." (At the time she thought she was laughing because of the aptness in saying facts and formulas don't mean much in life. Later, in conference, she explored another possibility. In their contacts, mathematics often symbolized life; therefore, when he said it meant nothing, she was negated, too. With a sense of discomfort and fear, she laughed.)

He elaborated that passing from boyhood to manhood was a sort of dying in which you took everything along. Was he saying that this relationship would remain even after she left?

"I'll be coming to see you for just three more weeks now." He didn't change expression though his coherency and speech rate altered. Talking of song titles, he shifted back to imagination.

"Ted, it isn't imagination! I'm real!" His denial was threatening and irritating to her.

"Well, of course you are. Who'd ever think they weren't?" Perhaps his denial hid previous doubts. Their talk shifted to the process of understanding; he insisted he used the most concise language possible--math and physics. Instead of helping him to see that most people don't communicate this way, she accepted with discouragement his unrealistic expectations.

Bluntly, he informed her, "My birthday is in four days. Seven pounds, seven ounces. And my father's name is August." These were the real fundamentals. As she started to leave, he stretched out his hand saying it was asleep. What was this--a sort of conversion reaction to keep from hitting or holding her or simply poor circulation? As usual, they walked to the

side door which she viewed as a testing grounds.

Passing the seclusion area, he remarked that he no longer slept there because they trusted him more now. It was his way of expression, he said to which she replied defensively, "Just as you have trouble expressing yourself, I have trouble understanding. Sometimes it works out and other times we miss."

His tone was sarcastic, "Yeah, they said I expressed myself in unusual ways--that's why I'm here. But there are a lot of abnormal people out there, too."

They stood apart as she took his words to be directed at her and left in a huff. In conference the nurse could see how her feelings had modified the interaction. Preoccupation with her own needs had blocked perception and initiated talk of termination. Increased expression of emotion was apparent from both the nurse and the patient.

Tuesday they were in better spirits. After showing his watch and billfold as if to individualize himself, he turned away and presented her with a red rose with these casual words, "Here--a man gave it to me and it needs to be in water." She accepted it smilingly and attempted to explore the meaning of the gift. He shied away.

The conversation was animated and interesting as it focused on his future plans, wardrobe, and the dance. He asked if she were going--it wasn't staff practice, and although she would have liked to, the nurse considered this a period in which he was decreasing his dependency.

He delved into his difficulty with girls and when it wasn't clear what he meant, he chided, "Oh, don't give me this sometimes jazz--you understand me most of the time. You came along right when I needed you the most--sympathetic. And that day of the fight--why, I was really low and

you were there. I was really crying. Like I was saying yesterday--some people look and look for something and never find it. Well, I have. It's like infinity. It'll go on and on."

She reminded him of the reality of her leaving in three weeks which he passed off as just the physical part. They talked more yet she hesitated to block his own feelings. It became more muddled--imaginary numbers and impurities and cards--and the symbolism seemed related to expression of affection.

During supper she sat where the attendants usually were, and brushing by, he said snidely, "That's where you belong." The conflict in her function, her sense of being attacked, and disinclination to be grouped with the staff arose again. At the table he cradled his arms and insisted, "Now let's get back to what we were saying--what are you going to do when you leave here?"

"You mean at school?"

He pressed impatiently, "Yes, back to classes--and that's all?"

The nurse realized he wanted to know how she felt about him, but when she asked, he looked away while shrugging his shoulder as if it didn't matter. She said she'd miss him.

While talking more about his troubles with girls, she tried to clarify her position as being similar but still different from others he had known. Yet, as she was striving for individuality, he maintained a certain vagueness which was underlined as he took off his glasses as if not to see her clearly.

Viewing his progress, he told dramatically how easily he was deflated. "Boy, my mother sure knows how to cool me off!" The nurse shared his anger toward people who undermined his self confidence--she wasn't prepared for

his next comment. "Somebody can make me feel just so big. Then I've got to crawl up again. You do that sometimes."

Her surprise and disbelief echoed in her reply, "I do?"

He couldn't explain this directly, but illustrated it by asking what her first name was and where she lived. "I wonder why you're asking," she queried.

"There you go again--making me feel so high!" Apparently, her refusal to share some things and an insistence on the professional focus of their relationship made him feel uncertain and confused at times. Therefore, he retaliated by belittling her therapeutic efforts.

Following this verbal aggression, he mused on that maybe the song titles were right--maybe there was a home in the wilderness. The nurse reflected his thought that maybe there was love. They sat in comfortable, close quietness until she had to leave.

From a student she learned that Ted had proudly told the group that his nurse came to see him exclusively. It made her glad that she had focused so much on him by declining interaction with other patients, and despite an emotional day, she went to see him in good spirits. He put away his cards as just time-passers and began to tell her about plans for a hospital detail. When she remarked about having the future on his mind, he sighed deeply and said, "Yes, I do. Well, you've got to look ahead and take care of yourself." Hints about his weekend pass weren't picked up on. Again he puzzled, "Math can be pretty confusing. You know, if you really study it long and hard--really keep at it--it turns out to be a lot of nothing!"

Again she laughed uncomfortably and he looked perturbed. His verbal testing increased as they discussed their relationship. Putting out his

hand, he asked, "Let's see yours." As they matched palms, he marveled at how much bigger his was and then briefly slipped his fingers down into a coy little embrace. They were still talking as she went into the nursing station--she paused in the conversation and he continued. Perhaps she personalized their relationship more than he.

With a sense of guilt and dissatisfaction, she realized that they had talked little about his important weekend pass, and when she mentioned it, he replied, "Yeah, it scares me. Oh, I don't know. I'd rather just stay here and talk to you. I guess I'm just tied to your apron strings."

The nurse felt embarrassed and pleased by his dependence and tried to convey her interest by saying, "Well, I'll be thinking of you on your birthday." She had already planned to surprise him with a card.

He put his hand on her shoulder while asking, "What are you going to give me?"

It was very awkward--she was right in the middle of leaving with no time to explore this. "Hey, that really puts me on the spot!" she parried.

"Oh, can't you even take a joke?" With a big grin he turned away. She wanted him to know her spontaneous idea and in a firm, insistent, smiling way told him about the card--it wouldn't be just because he had asked.

He smiled and put out his hand. "Okay. It's a deal."

Even while doing so, she wondered what they were shaking on--a compromise in emotional expression? the realization that she couldn't give him everything? a face-saving device?

Throughout this interaction he seemed to concentrate on a shift in

their relationship to greater independence and relating to her on a sex-peer role. The latter was resisted as her own preoccupation blocked her perception of his problems. Later, she wished they had focused more on his feelings about his first pass home.

Fifth Week

The nurse found a birthday card which seemed appropriate and sent it to her patient. She was viewing his big weekend optimistically. Late Monday afternoon she learned that he had come back from pass early and was very disturbed again. A variety of emotions arose--concern, curiosity, and guilt that she might have done something to have prevented or precipitated this. As she entered the smoking room, he left the group of patients to join her at the window. He was sketching rapidly and didn't look at her as he remarked, "I didn't think you'd be here today--I thought you'd be with the boys." The strained tone was heightened by a dry, trembling laugh which continued. She realized that he was very tense but didn't know what to say to lessen this. When he sketched a bike, she tried to reach him by asking if it were the one he'd told her about previously. He responded by describing the picture of a truck loaded with explosives and a driver who might lose control. Was he both the truck and the driver?

It seemed that he didn't know if he could tolerate her presence or participate as before, and on learning that she'd be staying a half hour, he brought along a magazine to their table. The dreadful little laugh kept on.

"Two weeks now?" he asked.

"That I'll be here?"

"Yes. And then you'll be going back to upper campus." While

sketching the university grounds, he went into a quiet monologue of what had happened the previous day--a dreamlike confusion which could have happened. When she interrupted listening, he asked her in pressured tones how much time they had left. Every few minutes he repeated the question until she said she didn't know if he wanted her to stay or to go.

His sad, desperate tone lamented that there wasn't time enough--it was her decision to stay for a longer time than planned. He moved to another table and when she joined him, it seemed he was trying to establish contact with her. First their elbows on the table touched; then, asking what her name was and how to spell it, he said, "We better check those hands again." She matched his upheld hand like the previous Wednesday, and as his fingers interlaced, she gave a little squeeze and patted his hand to let him know she was trying to understand. However, did he get the message? His mood called for further exploration. "You're pretty upset today. I guess a lot has happened since I saw you last."

"Yeah, and I've been waiting for you since three o'clock." He was peeved.

"You expected me then?"

He picked up her hand and counted off the hours by bending her fingers back in a way that could have hurt with pressure. Shifting to take her pulse, he said he couldn't find it.

She symbolically queried, "So you think I don't have a heart?"

"I guess you had a busy day."

Her reply indicated understanding of his disappointment, but later she realized his irrational expectation of her omniscience. Her concern and verbalization of his anxiety seemed to alleviate it somewhat as the laughter decreased and he talked more coherently about coming back to the

hospital. This switched into phantasy as with a dreamy monotone he talked of a bridal bouquet, a cradle, and being with someone.

He began sketching on the oilcloth, and the nurse became increasingly worried whether this was allowed. Though realizing his writing was important, she feared criticism of him and herself. It was with mutual embarrassment that she asked him to stop and erase it. As if to obtain as simple a solution to his present problems, he asked, "What'll I do?

Sighing in discouragement over her lack of understanding, she said she didn't know what he was asking. He, too, sounded discouraged and disappointed. The monologue resumed as he mentioned the birthday card, but her concentration was shot. He took hold of her wrist to detain her, and they talked over his wish for her to remain.

She felt generally upset for him and yet intrigued by his changed behavior with the increased nonverbal communication. It seemed that his disorganization was related to a variety of experiences in which she was a factor. Perhaps the inadequacy of his pre-hospital adjustment was more apparent because of the interpersonal relationship with the nurse. The testing of her interest and understanding had increased again along with the realization that she was leaving soon.

This testing was intensified the next afternoon. Raising up from fiddling with his shoes, he declared, "I know your name--you're a thousand names rolled into one." His words were short and clipped while a dreadful, quavering laugh that sounded like crying ran over and through them. In order to see and hear him clearly, she had to bend forward to match his posture.

"Well, what do you think?" he challenged in an angry, direct way.

"I don't know what to think," was her weak retreat.

Shaking his head, he sneered, "That's what I expected! Dingaling--too many dingalings! Do you know Mr. Green? He acted a little dingaling and they took him to jail--yet he was the sanest one in the bunch. Yeah, to the hospital--jail. The wonderful college of insane knowledge! The hoSPITable! Spit it out! And they didn't want anyone to know I'm here--that I'm in California. Well, here's a couple who know it." He thrust as proof two envelopes addressed to him.

To help him sort out his anger, she commented, "I don't know if you're mad because your parents don't want anyone to know you're here or because people do." Identification of his mood would have been better than jumping the gun with her own speculations.

The angry tirade continued and centered around his helplessness and domination by his mother. "And then they put-put-put-put-put-put me in here! In the hoSPITable! They say I'm nuts--I <u>am</u> nuts!" With this outburst his laughter was decreasing. When a mocking rock and roll song blared out, "Happiness--yah, yah, yah, yah!", he moved ominously as if to shut it off the television and out of his mind.

The nurse finally said the obvious in bland tones, "You sure are mad today."

"I'm not mad; I'm upset." He qualified his mood, and with this recognition of feeling, he relaxed. Almost apologetically he commented that she was an hour early--a distortion of time to convey his awareness of her interest? Though he left abruptly when the dinner bell rang, the nurse decided to wait as was usual on Tuesdays; otherwise, he might take this as a rebuff for his hostile behavior.

She tagged after him to the crowded smoking room to hear another

patient ask him, "What's her name?"

"Puddentane!" he quipped. He seemed to depreciate yet prize her at the same time. When he asked her to play cards, she agreed thinking maybe he needed this camouflage. In response to someone's question, he denied casually that he had a special nurse--the room was full of confusion and conversation. His strange laughter rose to a high pitch as the tension increased.

The card game was bizarre with rules made up as they went along. He seemed to attach individual meanings to the cards, but her efforts to understand these were thwarted by another patient joining the game. Structuring the time, she said she'd be leaving in ten minutes.

"Make it five," he replied tersely. The game ended, and she quietly watched him deal out cards.

"So you're playing solitare?" Solitare--a lonely game.

"I have been for twenty years," he replied in the same sad vein. She began to leave by saying she'd be back the next day.

Without looking up and in a steady, soft tone he said, "You better not make it."

"Better not come?" Her surprise was evident.

"Don't come. I don't need your help any more."

She leaned closer to whisper, "I'll be back on the ward tomorrow--whether you see me is up to you. But I want to see you."

The calm words had belied her confusion for the nurse felt very anxious. She felt that she had to talk it over with someone to be more effective the next day. The instructor agreed to spend some additional time with her--talking it over and clarifying his rejection relieved her

immediate pressure. In a later conference the connection of patient-nurse-instructor became more apparent in realizing that the previous day she had given more time to her patient, and in turn, the nurse asked for and received additional support for herself.

It had already been an emotional day for the nurse before she got to the ward to hear that Ted had been more upset at bedtime again--crying and secluded. He threw down a cloth disgustedly, "That's all!" and paid no further attention as she sat beside him. A very talkative patient ignored her comments that she was there just to see Ted. Her patient kept laughing continually in a very uncomfortable way--she felt very sober.

A strange mental hospital drama unfolded as several patients came in from their farm jobs with smuggled ears of corn stuffed in their shirts. With furtive intensity they were passed around, shucked, and eaten raw. Ted savagely attacked his while muttering how good it was. Her sense of horror suggested the symbolic enactment of an infant devouring the breast. The primitiveness shocked her yet she reasoned that maybe it was good--their food was usually poor and maybe he felt obliged to follow through. The second ear he broke and handed her half as his first sign of recognition.

The talkative patient monopolized Ted as she grew increasingly annoyed at being ignored and unable to limit the man. She broke in, "You said yesterday that I shouldn't come back."

"Oh, I didn't mean that. I was mad at you."

"Mad at me? How come?" Perhaps the flipness of her phrasing showed disinterest.

"Oh, all that shouting--all the others." As the situation was being reproduced this afternoon, she whispered her annoyance which he took to

mean she didn't like him anymore. With that cleared up, they went into the hall for privacy. He took off his glasses while almost crying, but she soon had to leave.

His voice and manner were firm, "Okay, but I'm going with you." She said he couldn't and saw him whirl around throwing his hands up in the air. It was her fault, and she felt obliged to follow him. "I know you're upset now, Ted."

"I don't want you to come any more." Again they hadn't time to discuss this, but, both upset, they walked down the hall. As they passed the short hall corridor, he indicated, "This way?"

She was hurried and firm, "No, I'm not going that way. You're upset, Ted, and I don't know what to expect from you."

He sarcastically replied, "Oh, you can figure me out." He said that it was all buried and couldn't be consecrated.

Although she had an inkling, she blurted, "Oh, Ted, I don't know what you mean here and I haven't got time to be able to understand it. We need to talk this over about my coming back." An attendant was letting someone in the door, and she felt his presence protective.

Ted warned, "Don't come back--do you hear me?"

"Yes, I hear you, but I will be back." Her tone was certain and calm.

"NEVER COME BACK!" he shouted as she left. The intensity of his feelings was frightening even though she had encouraged his expression of hostility. Perhaps she had provoked this by insisting on seeing him. Wishing she had shared more with the staff, the nurse hoped that they wouldn't blame her for his disturbed behavior.

Sixth Week

His angry words echoed in her ears. The instructor asked if she had promised to return and mentioned that this would take courage. The nurse, despite her hesitations, realized she was committed to return. Originally, a conference discussing the last week's interaction was to precede her visit, but she went early. She explained to herself that the time was more convenient; later, it seemed a testing of her capability to function without the instructor's help.

In wondering what would happen, her heart pounded as Ted intercepted her. Disheveled with glasses off, he asked in a low tone, "Oh, did you have to come?" Was he saving face by placing the responsibility on her?

"Well, the last thing you said was for me not to come, yet I said I'd be back." Tackling the initial problem, she watched him closely.

"Yeah, and I've had a rough weekend. Come here, and I'll tell you about that." His hurt tone told her to stay. As they turned into the dining room, she realized she hadn't let the attendants know she was there. Perhaps this was a feeling she could handle the situation--perhaps bravado--perhaps a reluctance to antagonize the patient by any delay or hint of rejection.

Throughout the whole time, he seemed on the verge of tears as he looked down and talked softly. He minimized his previous words by saying it was just to boss her around. The emotional climate deepened as she remarked, "You look so very sad."

His reply about loving her was followed by talk of war, bombings, and General MacArthur, who also returned. His ambivalence was obvious though his words were almost too soft to hear. The tears were less emergent

when he spoke of his parents who didn't return when he threw them out.

During this time, the table was being set for supper, and as the milk was poured, he asked for it. The nurse felt trapped between the reality and symbolic situations. The milk was for supper; he was asking for something she could give him. But in light of her leaving, he should be weaned by now. Nevertheless, he reached across and drank it anyway while smiling. As he fiddled with the broken earpieces of his glasses, she wondered what relation this had to his usual apparent phantasy use of them.

Starting to leave, she excused herself by saying she had to see her instructor. Was the specific reason to prepare him for her final leaving on Wednesday? It wasn't that she wanted to; she had to.

Ted looked at her hand and with unusual intensity asked her to keep wearing her ring.

"I don't know what you're asking, Ted?"

"I'm proposing to you. I want you to marry me." These words surprised her as she wondered what he was groping to tell her. "Well, you do love me, don't you?" he asked searchingly.

Hesitantly, she replied, "Well, yes I do. But not in a marriage way." As they tried to understand what each other meant by love, he told the nurse that she had expressed it fine before and to her surprise quoted, "For God so loved the world that he gave his only begotten son that whosoever believeth on him should not perish, but should have everlasting life." The immensity awed her.

He asked for more milk which she refused again; he drank a second cup while telling her, "Just sit here and love me for a while. Her reluctance weakened as she passed him the half-empty cup to finish up. In this

way she reached some sort of compromise between the needs of the patient, her sense of nursing care, and a responsibility to the ward. She refilled the cups; he was emptying his third one as she left.

The next day his broad smile and rustling of a magazine increased with agitation as she delayed going out to him. He greeted her briefly then lapsed into a dreamy reverie though he smiled at her occasionally. Sitting quietly, the nurse wondered at his change of behavior. At supper time, he asked her to wait, but afterwards walked right past. Then, rushing up, he asked her to listen to music with him. The strange, complacent smile hovered over his features. He had lost track of the day and she remembered hearing that he had called another nurse by her name all morning. It made her feel somewhat rejected, depreciated, and yet hopeful that he might transfer the positive aspects of their relationship to others in the future.

With a casual tone he asked, "Well, do you still love me?" It sounded like he considered it a big joke.

"If you mean care about you, yes. But I'm not quite sure we mean the same thing by love." Again they struggled for mutual understanding.

Perhaps to break the intensity he suggested they watch television though there was no image on the damaged set. "Boring, isn't it?", he asked and she inferred he was testing her reaction to him.

Next he reached over and took hold of her hand, "Let's hold hands."

She felt a little flustered wondering how this looked to others but was able to focus on the meaning with him. He told her that hand-holding was like talking but didn't elaborate.

Patting his hand gently, she withdrew hers as if to say that she couldn't speak the language without knowing the vocabulary.

"I asked you to marry me yesterday, and I meant every word." His emphatic tone caused a little sinking feeling for her naive hope was that he had forgotten this. When he declined to discuss it, she fumbled with words to say their relationship wasn't a boy-girl one leading to marriage.

"I understand," he sat back quietly. Did he or didn't he? Getting up, he told her to half circle the room in an opposite direction from him, and she did so. It seemed to mean that although they went separate ways, they had met. Again she gave the specific reason for leaving, and in response to his wave, she said an unusual, "Good night." Was this her magical attempt to help him over the rough evening and secluded night?

The nurse was aware of many feelings on the last day--regret that it was to be all over, fear that she hadn't done enough, recognition that the thesis data would be collected and relief that the recording--and interaction--would be over. She summarized with his doctor to provide some awareness and continuity of treatment. With the ward staff she shared some observations but found it hard to put into a few words the many things that had happened.

Ted was bending over his slippers as he said perplexedly, "I feel bad--awfully bad." To her inquiry, he replied that he was a dingaling. She knew this was the local jargon for psychotic--what was his use? Pointing to the short hall corridor, he suggested they go down there to talk.

She realized how charged with emotional import this area was and began to ask him more when their steps were halted by a shouted command from an attendant she'd never seen before. "Sonderson! Get back in that chair!" Her patient sat down quickly, and with indignation, she joined him.

The attendant told her tersely that he was sorry but there was a reason.

Her attempt to understand Ted's view was blocked as he intently began talk of love and marriage again. His pleas seemed to be for recognition that she would still care for him, and on saying she would, he stopped.

The banging of the pipes distracted him as he frowned and held his head, "Those drums--I wish they'd stop them. They say you're dingaling and I don't want to hear that!" Ambivalence? Rejection?

When the nurse expressed her regret to leave him, he countered with a hurt and angry, "If you think you're sad, how do you think I feel?" He spoke again of how she'd helped him and asked to hold hands.

With no clue as to what this meant to him, she realized that he withdrew his hand as she patted it--perhaps the contact was too threatening. Again the pipes banged, "Those drums--you're not a dingaling and I'm not a dingaling. I love you--you're the one who carries the keys--the only one on this ward. So you will marry me, won't you?"

It seemed he meant that their level of understanding was different from that he had with others. Perhaps the key she carried for him was the nurse-patient relationship in which they struggled toward the solution of mutual understanding.

Her reply was simply, "Ted, I guess we mean different things for I've told you that I won't marry you. You don't have to ask that for me to say that I won't forget you. You mean a lot to me."

His talk was less coherent as he wove in and out of phantasy; she saw again the confused roles in which he viewed her and realized that he was becoming more frantic in tone and speech.

She sadly made her last comment knowing the words might sound silly. "It's hard to say goodbye. I like you very much, Ted. I hope that you've gotten something from our relationship that helps you to see there are other people with love and affection and that you'll be able to transfer this to them."

He was looking down with no answer as she said brief goodbyes to the attendants. Putting her hand on his shoulder, she said, "I have to go. Goodbye, Ted."

Still looking down and with a very forlorn tone, he replied, "I can't say any more now." She accepted his goodbye as sadly appropriate for her thesis on nonverbal communication.

Outside the ward, she cried a little--sadness, relief, regret? The six week period was over, and she had a wealth of data. As far as actual contact their relationship had terminated, but she felt certain that this interaction would continue to have meaning over a period of time. This last day seemed to be the realization that two people who have come to mean a lot to each other were now separating with mutual awareness that interpersonal involvement can be gratifying, frightening, intriguing, painful, and potentially therapeutic.

CHAPTER V

ANALYSIS OF ONE THEME

Introduction

Analysis of the data was an integral part of the study. The investigator became aware of the variations in perception and memory which screened her responses in the situation and affected subsequent recording. The inclusion of verbal communication was found necessary in order to interact, record, and analyze in a more realistic, accurate, and meaningful fashion. Weekly conferences with the instructor focused on the concurrent analysis of the immediate nurse-patient relationship to provide greater understanding and more effective intervention. As anticipated, definite themes were discovered through this scrutiny.

A single interaction may consist of many themes, and one theme may be derived from a continuum of interactions. Dominant patterns are composed of interweaving threads. Throughout the study the recorded data were analysed from many standpoints. Additional examination suggested that the total nurse-patient relationship could be approached from several thematic views including patterns of control, environmental effect on interaction, nurse-patient role differentiation, physical contact, instructor-nurse-patient networks, and fluctuations in the expression of aggression and approval.

The purpose of the study was to identify and examine the themes of a nurse-patient relationship by concentrating on the observed nonverbal communication. The following analysis of one dominant theme was presented

to illustrate the approach, through nonverbal communication, by which the emerging patterns were recognized and utilized in the interpersonal relationship.

Identification of One Theme in the Nurse-Patient Relationship:

Fluctuations in the Expression of Aggression and Approval

First Week

Nurse: Frustrated in seeking approval in several areas with resulting depression and anger. Selected a reportedly aggressive patient and interacted on basis of prior experiences. Utilized tone, attention, facial expression, physical contact, and verbal content to explore communication system. Responded to patient's rebuffs with alternating acceptance of the rejection and insistence on the relationship. Denied personal threat of overt aggression. Denied importance of approval from staff.

Patient: Employed behavior patterns which were interpreted by staff as hostilely aggressive and responded to by staff with reciprocal force. Tested limits of approval from nurse by cooperation, rejection, coherency, verbal content, tone, physical contact, and use of space.

Theme: The orientation of two strangers to each other's modes of communication in order to determine the limits of approval and aggression within the interaction.

Second Week

Nurse: Motivated more highly. Increased focus on patient with interpretation of his behavior as need for mothering. Offered this nursing role by tone, interest, and exploration of feelings. Recognized her own conflicting attitudes toward expression of aggression. Accepted approval from patient and instructor. Re-evaluated effect of staff's opinions on her spontaneity.

Patient: Attempted to define necessary behavior for approval from nurse. Expressed aggression through negation, tone, rejection, increased animation, and fighting. Sought approval through expression of helplessness, tears, and verbal recognition of the nurse's importance.

Theme: Identification of the nurse as a helping person who obtains her sense of approval by giving and of the patient as one who secures approval by accepting. Experimentation with the expression and acceptance of aggression.

Third Week

Nurse: Obtained approval from instructor and change in patient's behavior. Increased maternal focus. Encouraged verbal expression of anger. Shared disapproval from another patient. Reinforced verbal expression of affection by physical contact. Recognized her own need for approval and wondered how this influenced his expression of approval and aggression.

Patient: Responded to mothering with increased directness of feelings, sharing of past experiences, and monopolizing nurse through segregation. Softened verbal hostility toward her by smiles and tone. Began tentative verbal hostility toward his mother. Expressed approval through verbal content, physical contact, recognition of nurse's nonverbal communication, and efforts to please and impress her. Followed expression of affection with destructive thoughts toward her.

Theme: Exploitation of the relationship by both the nurse and patient to satisfy reciprocal mother-child yearnings. Increased exchange of approval and the nurse's encouraged expression of aggression from the patient.

Fourth Week

Nurse: Experienced lack of approval from instructor with resulting depression. Became preoccupied with termination and interpreted patient's behavior as rejection. Expressed aggression through laughing, verbal content, increased animation, and physical withdrawal. Accepted flower as sign of approval. Anticipated patient's need for approval regarding his birthday and was more direct in expression of feelings.

Patient: Decreased verbal approval of nurse despite her solicitation. Expressed affection through segregation, giving her a flower, more adult physical contact, and increased awareness of nurse's behavior. Expressed aggression by distance, tone, denial of nurse's importance to him, verbal content, direct criticism of nurse and comparison with his mother.

Theme: Exploitation of the relationship as both nurse and patient express emotional responses to each other with increasing directness. The beginning of termination.

Fifth Week

Nurse: Regarded his disturbed behavior as due partially to her influence and feared disapproval from staff, instructor, and patient. Delayed discussing his feelings. Evaluated his changed communication system in light of their previous experiences. Decreased her verbal participation to indicate acceptance. Increased the amount of time she spent with him and obtained additional support herself from instructor. Tolerated aggressive words, tone, and actions with increased facility to explore

these. Recognized caution in avoiding isolated areas of the ward to decrease possible destructive aggression from the patient.

Patient: Returned to individualized expression of approval and aggression. Intensified testing of nurse through rejection, sketching, verbal content, tone, actions, physical contact, laughter. Expressed anger directly toward nurse and family through words and actions. Decreased agitation when feelings were recognized by nurse.

Theme: Exploitation of the relationship by the nurse to provide the patient with a successful experience of handling aggression with a significant person who is able to maintain approval.

Sixth Week

Nurse: Sought approval of capabilities by seeing patient before conference with instructor. Avoided antagonism but verbally initiated problem of acceptance. Recognized conflicting feelings in her responses to the patient's milk drinking actions. Accepted and explored meaning of symbolic verbal content, physical contact, and feelings. Experienced self-disapproval for not participating more with staff until behavior clarified with instructor.

Patient: Rationalized expression of aggression in order to maintain nurse's approval. Interpreted her return to see him as approval. Internalized aggression in depression, withdrawal, and symbolic expression (phantasy, drinking milk, and broken glasses) as evidenced by posture, tone, facial expression, actions, verbal content, and physical contact. Sought approval through verbal content, physical contact, and action.

Theme: Termination of a relationship in which mutual needs for approval and aggression were expressed and reacted to with an increasing range of recognition and utilization for therapeutic benefit.

Total Relationship

Nurse: Increased her sensitivity to patient's unique communication system through participant observation. Recognized her own conflicting feelings about the expression of aggression and approval by both the patient and herself and developed more ability to channel these therapeutically. Experienced more fully the instructor-nurse-patient interplay. Developed further her communicative skills.

Patient: Experimented with many modes of behavior through interaction with nurse. Utilized expression of affection to control situation. Channeled expression of aggression for more therapeutic experiences. Explored the nurse's and his own communication systems with varying degrees of gratification and frustration.

Theme: Within a nurse-patient relationship, the participants' expressions of aggression and approval fluctuated with their needs and behaviors which were subject to study and modification.

Some Aspects of Nonverbal Communication

The theme of the fluctuations of the expression of aggression and approval was derived from the total communication system as recorded. Some aspects of the nonverbal communication contributing to this generalization were:

1. Mood and general attitude as derived from subjective and objective observation prior, during, and following the interaction.

2. Speech patterns of tone, volume, pausing, intensity, tempo, animation, coherency, quantity, sighs, and laughter.

3. Body movements of proximity, contact, level of activity, withdrawal, posture, stiffness, tears, smiles, and interaction with other people.

4. Inanimate objects as pipes, cards, glasses, ring, magazines, shoes, keys, flower, birthday card, corn, clothing, and milk.

5. Time as utilized to control the interaction, symbolize approval, evaluate responses, and relate the conferences with ward behavior.

6. Areas on the ward: alcoves, patient's room, and seclusion area being places of more uninhibited, regressed behavior; smoking room, halls, and dayroom being areas of more social interaction; dining room as a compromise for sanctioned privacy; the two exits.

CHAPTER VI

SUMMATION

Summary of the Study

Interaction is an integral part of every nursing situation. In order to develop and utilize the nurse-patient relationship to the greatest therapeutic benefit, the nurse needs an awareness of what is going on in the situation. The complex communicative network provides the means by which the nurse and the patient exchange their needs and satisfactions through shared experiences.

The purpose of the study was to identify and examine the themes of one basic nursing unit, a nurse and a patient, by concentrating on the observed nonverbal communication. This was done by establishing a relationship, recording the interaction, and analyzing the data. Through this process a dual goal was attained--a descriptive account of a nurse-patient relationship in a psychiatric setting and an examination of an approach to studying it.

The use of nonverbal communication was a focus for particular study in both the interaction and the analysis. Verbal expression was a necessary inclusion for continuity and clarity.

The study was considered exploratory in an individual and general way. As a unique experience, it provided the investigator with an opportunity to examine closely her interaction with a patient. This was expanded into the general framework of identifying some of the problems and applications of this type of research.

Conclusions

The conclusions that were drawn from this study were categorized as pertaining to the nurse-patient relationship, the method of analysis, and the nonverbal communication. It was recognized that additional study of the data might lead to further conclusions in each area.

The nurse-patient relationship

1. A nurse-patient relationship can be established for the purpose of investigative study.

2. Prior experiences and expectations affected the relationship; through focusing on the present situation, stereotyped behavior was reduced and the utilization of controlled spontaneity increased.

3. Interaction was modified by the influence and presence of other persons and by the emotional connotation of the specific areas of the ward.

4. Clarification of the interaction led to increased effectiveness in understanding the patient's needs and in participating in meeting them.

5. A focus on the communicative network facilitated increasingly more accurate participant observation.

6. The instructor was an important part of the total interaction and helped to objectify data and facilitate recall.

The method of analysis

1. The analysis of the data was inherent in the process of participant observation.

2. The instructor participated in the concurrent analysis through clarification, expansion, and validation.

3. Difficulties were encountered in regard to the quantity of the data, the lack of a formal structure as a guide for analysis, the large amount of time necessary for recording and reviewing, and the anxiety of the investigator in response to repeated survey of her nursing behavior.

4. The concurrent analysis was used in the interaction, and the data are now available for multiple use.

The nonverbal communication

1. The focus of the analysis was on nonverbal communication, but the total interaction was necessary for understanding the meaning of the behavior.

2. Sensitivity to nonverbal expression developed increasingly through a cumulative process despite fluctuations during periods of greater stress and when the mode of communication shifted.

3. Specific usual patterns of nonverbal expression of both the patient and the nurse emerged.

4. Difficulties were encountered in observing, recalling, expressing, and recording the behavior.

5. An understanding of the meaning of the behavior required that the nurse participate further--it was not enough to focus and to listen.

6. The observation and analysis were biased by the emphasis on nonverbal communication and this influenced the interaction.

7. Nonverbal communication can be used in identifying themes in a nurse-patient relationship.

Implications for Nursing

The conclusions drawn from this study have implications in the areas of nursing practice and nursing education. For nursing practice, they suggested the need for continual inquiry into nurse-patient relationships in order to identify needs of patients and the functioning of nurses to meet those needs. The general context of the ward was important in establishing a therapeutic relationship. The role of the instructor pointed to the need for supervisory personnel who are capable of helping the nurse to understand her interactions with patients. The method of study and the body of data suggested usefulness in in-service education programs.

For nursing education, the study illustrated the use of the examination of a nurse-patient relationship to increase awareness of self and patient in order to develop nursing skills. The data, an example of nursing care in a psychiatric setting, can be examined further as an illustration and testing area of nursing concepts.

The focus on communication suggested the need for greater emphasis on this area in both basic and graduate programs with experimental learning experiences such as drama and dance. The importance of nonverbal communication in the study suggested that sensitivity and skill may be developed further through an educational continuum. Previous learnings, such as attitudes toward physical contact, required re-examination as to the application in this instance of nursing care. The prolonged contact with one instructor emphasized the importance of faculty members who are capable of helping the student to integrate her total learning experiences.

Recommendations for Further Study

Many of the facets of this exploratory study suggested further investigation of nurse-patient relationships. Some specific areas were:

1. Interaction studies in all clinical areas to describe how other nurses are functioning.

2. A study of the effects of the immediate environment on the nurse-patient relationship in a psychiatric hospital.

3. A more extensive study of nonverbal communication through recording by motion picture along with participant observation.

4. Search for more adequate methods for analysis of the raw data.

5. Exploring the use of modern dance to develop communication skills of students of nursing and the personnel and patients in psychiatric hospitals.

6. A nurse-patient relationship study in which the use of time as a means of nonverbal communication is examined.

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APPENDIX A

AN EXAMPLE OF THE ORIGINAL INTERACTION NOTES

The capitalized comments were inserted following the conference with the instructor. This excerpt was from recording during the fifth week of the study.

NURSE	PATIENT
COMPARE THIS WITH SEEING H. THE NEXT NIGHT I don't know whether you want me to stay or go...? (I was somewhat annoyed and asking him to help me make up my mind, too.)	
	There's not enough time--how much longer?
(He sounded so very desperate and pressured that I decided that I would stay and said) Well, I am not leaving in five minutes. CONFUSING TO HIM ABOUT THE LIMITS OF THE INTERACTION? I GAVE HIM MORE THAN I PROMISED	
	(He reached over to adjust the blind, it flew out of his hand and up. Sunlight flooded me and he got up and moved over to the next table--he moved the chair out a little while I kept looking at him. Then he came back to our table and looked and I asked) Yes. (As I sat down at the table with my elbow on it, he moved his arm over until it touched mine--I thought that this was his way of saying that he wanted to establish contact with me--he asked) What's your name again?
Want me to come over there?	
(I hesitated thinking whether I should quiz him on what it was, but decided that he should know it--irritated) Miss Prodan. PRODAN	
	How do you spell it? We better check those hands again. (He held up his hand and I matched--then his fingers slipped down and

NURSE	PATIENT
CHILD HANGING ONTO MOTHER. I gave his hand a little squeeze meaning that I was trying to understand what he was going through. Then I put our hands down on the table and patted his with my other one. I felt that he was really reaching out for me and that I wanted to convey my acceptance of him in this more disturbed state. Yet I did feel somewhat hesitant wondering what anyone looking on might think as well as if he was getting a different idea. I decided to bring up my impressions and open the way if he wanted to explore the past days.) You're pretty upset today. I guess a lot has happened since I say you last.	interlaced with mine.
IRRATIONAL EXPECTATION YET I WENT ALONG WITH HIM You expected me then?	Yeah, and I've been waiting for you since 3 pm.
	(He picked up my hand again and counted the fingers 3,4,5,6--that one he bent back not to hurting but in the way that could have. Then he started taking my pulse and twisted my hand around to take his.

APPENDIX B

CATEGORIZATION OF ONE INTERACTION

This was the first step of the retrospective analysis. The example was the classification of the first day of the fifth week.

1. My mood

I had made a special effort to get and sent him a birthday card that seemed to be appropriate and friendly. . . I knew that this was a big weekend for him yet was viewing it optimistically and from reviewing our interactions I felt that he was gaining from our relationship. I was late getting to the ward and wondered if he would be lying down like the last time. Then I was told that he had come back early from his pass, had "blown up" again, and was upset. Concerned, surprised, and curious. Guilty for I thought I could work better with him now and how I had failed so that he was upset. Cautious as to our outcome.

2. His mood

Very upset and tense--discouraged over his setback and all that had been happening to him. Testing out how I felt about him in this state.

3. Areas

In the smoking room where we stood together and talked and then going to our table and moving to another one. Looking out the window. I left by the front door.

4. Specifics of nonverbal communication

The card I sent to show I cared; walking over to me and drawing picture while explaining it; new pipe; quiet tones and sad sound--laughing a dry little nervous laugh; blocking my view and telling me not to look; bringing magazine to hide behind; fooling with window cords; sketching upper campus; decrease in laughing and musing in phantasy story; my turning to window and his moving to other table; time factor in my interest; touching of elbows then checking of hands; bending my fingers; disgusted tone when telling of short hall; my curtailing his writing and erasing it; quiet tones with decrease in laughter; taking hold of my hand to detain me--mutual waving from court.

5. General theme

Disorganization and whether I was still interested in him--whether I'd accept him this way and whether I could understand him.

6. Conference

Didn't I realize that my leaving would upset him? I was very reluctant to identify his mood and move in to give him ego support--he needed me and I shied away from the problem. Guilt from my showing him

the inconsistencies in his life. Confusing to him by my prolonging the time I'd give to him and then I demanded the same for myself the next night. His re-establishment of contact like with a child. Why did I go along with his irrational expectations of my anticipating his needs? Therapeutic concern to help him see how he asks the impossible. My focus which slipped and made him stop the writing and my embarrassment yet inability to say how stupid I was--controlling and acting on no basis. Difficulty in exploring what he means when he asks me what to do--avoiding his concepts. Difficulty in setting and keeping to the limits about leaving.

7. Influence of other people

Felt an increase in concern of staff about him and recognition from patients that I was his nurse. Interrupted by one patient which helped me reaffirm this. Somewhat concerned about handholding for fear of what they'd say also limited his writing on this basis--made me angry at myself.

APPENDIX C

SUMMARIZATION OF ONE WEEKLY PATTERN

This was the third step of the retrospective analysis. The example was the pattern summarized from the fifth week.

Theme. Aggression as a means of handling frustration from disappointing interpersonal relations can be channeled to help the patient experience acceptance. The nurse assumes responsibility for interpersonal involvement, even though risky. Exploitation and termination are the phases of the nurse-patient relationship operating here.

Nurse. Increase in professional awareness with feelings of responsibility for precipitating disturbed behavior. Decreased verbal expression while trying to relearn his communication patterns. Withdrawal in tone and content from his aggression. Giving and demanding additional time as indicator of willingness to help. Waiting while he ate. Awareness of others.

Patient. Decrease in coherency. Increased pressure--tone, activity, hostile, sarcastic. Continued laughing like crying. Attempting to establish previous contact through physical patterns. Use of drawing. Ignoring nurse--interacting with other patients. Primitive eating. Spontaneous, earnest tones then shouting aggression. Glasses and phantasy.

Areas. Smoking room with greater patient interaction than to table. Use of ward more. Nurse adapting to different areas--refusal to go to short hall.

END